

Unannounced Care Inspection Report

22 March 2017



Glenowen Court

Type of service: Residential Care Home
Address: 177a Andersonstown Road, Belfast, BT11 9EA
Tel no: 028 9060 2898
Inspector: Kylie Connor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Glenowen Court took place on 22 March 2017 from 9:30 to 16:00.

A lay assessor, Nan Simpson, was present during the inspection. Comments provided to the lay assessor are included within the report.

The inspection sought to assess progress with any issues raised since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

No requirements or recommendations were made in relation to this domain.

Is care effective?

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other key stakeholders.

No requirements or recommendations were made in relation to this domain.

Is care compassionate?

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

No requirements or recommendations were made in relation to this domain.

Is the service well led?

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

No requirements or recommendations were made in relation to this domain.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Siobhan Savage, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Fold Housing Association/Fiona McAnespie	Registered manager: Siobhan Savage
Person in charge of the home at the time of inspection: Siobhan Savage	Date manager registered: 2 November 2015
Categories of care: I - Old age not falling within any other category DE – Dementia (10 persons) MP - Mental disorder excluding learning disability or dementia and MP (E) - Mental disorder excluding learning disability or dementia – over 65 years (3 persons) LD - Learning Disability and LD (E) – Learning disability – over 65 years (5 persons) PH (E) - Physical disability other than sensory impairment – over 65 years SI – Sensory Impairment (2 persons)	Number of registered places: 44

3.0 Methods/processes

The following records were analysed by us prior to the inspection: the previous care inspection report, information regarding installation of a number of green break glass units and accident/incident notifications.

During the inspection the inspector and lay assessor met with ten residents. The inspector met with two care staff, one ancillary staff, the registered manager, one visiting professional and one resident's visitor/representative.

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for one new staff
- One staff file containing supervision and appraisal records
- Staff training schedule/records
- Four residents' care files
- Minutes of recent staff meetings
- Complaints and compliments records
- Maintenance records for nebuliser
- Weekly cleaning records
- February 2017 newsletter produced by the home
- Accident/incident/notifiable events register
- Annual Quality Review report 2016 (draft)
- Minutes of recent residents' meetings / representatives' / other
- Monthly monitoring reports
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc

Questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. Two resident representative questionnaires and two staff questionnaires were returned within the requested timescale. Five resident questionnaires were completed with the assistance of the lay assessor.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 September 2016

There were no requirements or recommendations made as a result of the last care inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 September 2016

There were no requirements or recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with residents, residents' representatives and staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home.

Review of completed induction records and discussion with the registered manager and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff and review of returned questionnaires confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

Discussion with the registered manager confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005 and that records were retained at the organisation's personnel department.

Enhanced AccessNI disclosures were viewed by the registered manager for all staff prior to the commencement of employment. Personnel records reviewed confirmed that AccessNI information was managed in line with best practice.

Arrangements were in place to monitor the registration status of staff with their professional body.

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and included the name of the safeguarding champion, definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. A safeguarding champion had been established.

Discussion with staff confirmed that they were aware of the new regional guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the registered manager, review of accident and incidents notifications, care records and complaints records confirmed that all suspected, alleged or actual incidents of abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained.

The registered manager confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the registered manager identified that the home did not accommodate any individuals whose assessed needs could not be met. Review

of care records identified that individual care needs assessments and risk assessments were obtained prior to admission.

The registered manager confirmed there were restrictive practices employed within the home, notably locked doors, biometric passes and arrangements for residents' smoking materials. Discussion with the registered manager regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Inspection of care records confirmed there was a system of referral to the multi-professional team when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary.

Discussion with the registered manager and examination of accident and incident records confirmed that when individual restraint was employed, the appropriate persons / bodies were informed.

The registered manager confirmed there were risk management policy and procedures in place relating to the safety of the home. Discussion with the registered manager and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly e.g. COSHH, fire safety etc.

The registered manager confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced. Review of maintenance records of a nebuliser and cleaning records supported this confirmation.

Review of the infection prevention and control (IPC) policy and procedure confirmed that this was in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The registered manager reported that there had been no outbreaks of infection since the last inspection. Any outbreak would be managed in accordance with the home policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised with photographs, memorabilia and personal items. The home was fresh-smelling, clean and appropriately heated.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

Discussion with the registered manager confirmed that risk assessments and action plans were in place to reduce risk where possible.

The home had an up to date fire risk assessment in place updated on 12 January 2017 and all recommendations were noted to be appropriately addressed.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed on 8, 10 and 13 March 2017. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked weekly / monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Staff spoken with during the inspection made the following comments:

- “The training was a priority.”
- “There is loads (of training). The training is quite interesting.”
- “They walked me through everything clearly (during induction).”

Nine completed questionnaires were returned to RQIA from residents, staff and residents’ representatives. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received were as follows:

- “We are very happy that our father is safe at all times.” (Representative)
- “Always staff around to take care of residents and frequent checks in residents private room/flat.” (Representative)
- “Staff are very good and look after us well. You couldn’t complain about anything, everything is good.” (Resident)
- “The home is very good and staff are excellent.” (Resident)
- “Everyone is fully trained and competent, there is a very caring, personal culture in the scheme.” (Staff)

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0
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4.4 Is care effective?

Discussion with the registered manager established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of four care records confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessments and risk assessments (e.g. manual handling, bedrails, nutrition, falls, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. Discussion with staff confirmed that a person centred approach underpinned practice. For example staff described how a resident was supported to make the decision to stay permanently in the home when they felt ready to do so and in partnership with their family. Staff also described how building a rapport with a resident by talking about their interests and making them a cup of tea prior to dispensing their medication resulted in a positive outcome.

An individual agreement setting out the terms of residency was in place and appropriately signed. Records were stored safely and securely in line with data protection.

The registered manager confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of medication, accidents and incidents (including falls, outbreaks) and fire checks were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the monthly monitoring visits reports and the annual quality report.

The registered manager confirmed that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. The registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

Residents and a representative spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders. Staff confirmed that they had received training in communication/customer care. Minutes of resident meetings were reviewed during the inspection.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents. The registered manager confirmed that arrangements were in place, in line with the legislation, to support and advocate for residents.

Staff and a visiting professional spoken with during the inspection made the following comments:

- "There is no I in team here."(Staff)
- "Staff are friendly and the notes have been made available to me. Staff are professional and they listen....Staff know residents very well, their preferences and guidelines are followed up."

Nine completed questionnaires were returned to RQIA from residents, staff and residents' representatives. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received were as follows:

- “There is always someone around to help when I need it.” (Resident)
- “Every aspect of my father’s care is very effective.” (Representative)
- “Handover is great and is very helpful.”

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0
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4.5 Is care compassionate?

The registered manager confirmed that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

A range of policies and procedures was in place which supported the delivery of compassionate care. Discussion with staff, residents and one representative confirmed that residents’ spiritual and cultural needs, including preferences for end of life care, were met within the home. Discussion with residents, a representative and staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner.

Residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment. For example, staff use photos of meals to aid residents when making their daily menu choices.

The registered manager, residents and a representative confirmed that consent was sought in relation to care and treatment. Discussion with residents, a representative and staff along with observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents’ rights, independence and dignity and the importance of protecting residents’ confidentiality.

The registered manager and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents and a representative confirmed that their views and opinions were taken into account in all matters affecting them.

Discussion with staff, residents, a representative and observation of practice confirmed that residents’ needs were recognised and responded to in a prompt and courteous manner by staff.

There were systems in place to ensure that the views and opinions of residents and or their representatives were sought and taken into account in all matters affecting them. For example, residents’ meetings, suggestion box, annual reviews and a suggestion tree.

Residents were consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report which was made available for residents and other interested parties to read.

Discussion with staff, residents and a representative, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in

meaningful activities. For example, staff stated that all residents were invited to participate in or observe activities because they recognised the benefits of doing either. Arrangements were in place for residents to maintain links with their friends, families and wider community. For example, some residents attend local day centres, NI disability leisure and sport activities and events in local primary schools.

Staff, a representative and residents spoken with during the inspection made the following comments:

- “You have to respect their wishes to have a lie in. We all have lazy days.” (Staff)
- “In the morning we do the headlines in the paper....we have reminiscence activities, skittles and visits by pets.” (Staff)
- “The food is great.” (Resident)
- “Staff couldn’t be any better.” (Resident)
- “Staff rang to enquire how she was doing in hospital.” (Representative)
- “Staff are kind.” (Resident)
- “I feel lucky to be here. I feel wanted. Staff are excellent.” (Resident)

Nine completed questionnaires were returned to RQIA from residents, staff and representatives. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received were as follows:

- “Not only is my relative treated with respect but myself and visitors also.” (Representative)
- “I have every confidence in the management and staff to take the best possible care of (my relative).” (Representative)
- “Residents attend meetings and make decisions....residents feel they are listened to and are treated with the utmost respect.” (Staff)

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

The registered manager outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. The needs of residents were met in accordance with the home’s Statement of Purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff.

Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints. Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant’s level of satisfaction. Arrangements were in place to share information about complaints and

compliments with staff. An audit of complaints was used to identify trends and to enhance service provision.

A review of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice. There were quality assurance systems in place to drive quality improvement which included regular audits, monthly monitoring and satisfaction surveys.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read.

There was evidence of managerial staff being provided with additional training in governance and leadership. The registered manager had recently attended training in adult safeguarding and is to attend training in the role and responsibilities of the safeguarding champion. Learning from complaints, incidents and feedback was integrated into practice and fed into a cycle of continuous improvement.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability.

The registered manager confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

Review of governance arrangements within the home and the evidence provided within the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider/s responded to regulatory matters in a timely manner.

Review of records and discussion with the registered manager and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The registered manager confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The registered manager confirmed that staff could also access line management to raise concerns they will offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

The registered manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Staff and a resident's representative spoken with during the inspection made the following comments:

- "There is a great atmosphere, it's like a family." (Staff)
- "The registered manager answers all questions and gets the answers promptly." (Staff)
- "(My relative) has improved since being in here. There isn't a big change in staff." (Representative)

Nine completed questionnaires were returned to RQIA from residents, staff and residents' representatives. Respondents described their level of satisfaction with this aspect of the service as very satisfied.

Comments received were as follows:

- "The staff are all very helpful and it is very, very well managed by a great manager – they are all the best we could ask for." (Representative)
- "The manager is great and easy to approach." (Staff)

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards.



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